Benefits By Design 2016

AMWTP
Advanced Mixed Waste Treatment Project

Idaho Treatment Group

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Welcome

Welcome to Benefits by Design annual enrollment 2016. Benefits by Design is the flexible benefit program for the group insurance plans for the Advanced Mixed Waste Treatment Project (AMWTP). Benefits by Design allows you to design a personalized benefit package suited to your individual insurance needs and financial situation.

This Benefits by Design booklet describes the plan and serves as a summary of material modifications (SMM). The information in this SMM updates and replaces applicable sections of your current summary plan description booklet until new booklets become available. Review this booklet to choose your plan based on your needs. Refer to this booklet throughout the year as you have questions or need contact numbers.

Enrollment

You will enroll for your 2016 benefits through the Employee Self Service (ESS) Electronic Enrollment Function . Because the ESS resides inside the "firewall" you will need to access the system from an AMWTP computer. You will be able to enroll beginning at **6:30 a.m., Monday, November 2, 2015. The enrollment window ends Tuesday, November 17, 2015, at 12:00 p.m. Benefit elections made during annual enrollment will be effective January 1, 2016.**

Please note if you are on travel, vacation, or other approved leave of absence during the **entire** enrollment window, you will need to send your written election by e-mail to jonna.nielsen@amwtp.inl.gov or by fax to 208-557-0955 no later than 12:00 p.m. November 17, 2015 – ***no exceptions***. In this situation only, all enrollments must be received in writing. Telephone requests will not be accepted.

If you have technical questions with the Employee Self Service (ESS) Electronic Enrollment Function, please contact Curt Stewart at 557-6511.

Benefit questions should be directed to Jonna Nielsen at 557-6400 or Jennifer Robbins at 557-0930.

Please note that each benefit plan has its own rules, terms and conditions. Each plan is governed by its own plan document and has a separate summary plan description (SPD). This Benefits by Design explains how you enroll in the various plans and outlines some of the important features of the various plans. However, you must read each plan's SPD to accurately determine that plan's terms and conditions. If there is any conflict between this Benefits by Design and the plan's SPD or document, the plan's SPD and plan document will control. In addition, AMWTP reserves the right to modify, at any time, the amount employees must contribute to participate in the various plans.

Default Coverage

Every employee is expected to use the ESS process to make new benefit elections for calendar year 2016. Employees who choose not to complete the 2016 enrollment process will be automatically enrolled in the company sponsored plans as follows:

Benefit Option	Default Enrollment
Medical	Plan B based on your coverage level in 2015 (e.g., Employee Only, Employee and Family, etc.). A 2015 opt out will be enrolled as Employee Only in Plan B.
Dental	Will remain the same as in 2015
Optional Vision	Will remain the same as in 2015
Employee Life	Company provided life insurance at 2.25 times salary
Spouse Life	Will remain the same as in 2015
Dependent Life	Will remain the same as in 2015
AD&D	Company provided plus the 10 times salary
STD	Company provided plus the optional buy-up, if applicable
LTD	Yes
Flex Spending Accounts	None
Pre-Paid Legal	None

Remember, these benefit enrollment elections will stay in place for all of 2016 and cannot be changed unless there is a qualifying change of status. Consequently, you are encouraged to make your own elections for 2016 to ensure that your benefits package is exactly what you and your family want/need.

2016 Benefit Plan Changes Summary

Annually, the benefits package is evaluated to find cost saving and benefit enhancement opportunities. This year's evaluation has led to several changes as outlined below. Please read the entire Benefits by Design booklet since the information below is only a brief summary of changes that may play a factor in your elections for 2016.

1. **Insurance Carrier Changes**
   - United Healthcare to Aetna
     - Effective January 1, 2016, United Healthcare will no longer be providing medical, dental, vision, flexible spending, or EAP services for ITG. These programs will be administered and offered by Aetna. The change in carriers has enhanced the cost savings for the medical plan and resulted in lower premiums for medical, dental, and vision buy-up in 2016.
       - In previous years, employees electing both medical coverage and vision buy-up coverage were required to cover the same dependents under both plans. Due to Aetna now providing medical and vision buy-up services, effective January 1, 2016, this requirement no longer applies. Employees may elect dependent coverage as needed for medical and vision buy-up independent of each other.
   - AFLAC
     - Premiums for AFLAC policies will no longer be deducted from employees' pay. Employees wishing to continue their policies with AFLAC may do so at the same rate they currently have on a direct billed basis. If you wish to set up direct billing please contact Dawn Sheue at 307-733-2055.

2. **New Insurance Cards**
   - Due to the change in insurance providers, new insurance ID cards for medical and vision buy-up coverage will be issued. These new cards will be mailed to your home address prior to December 31, 2015.
     - Aetna dental does not issue insurance cards.
       - Your dentist can validate coverage using your name, date of birth, and ID number (or social security number).

Please note that the current United Healthcare cards need to be used until December 31, 2015. New cards are only applicable beginning January 1, 2016.

3. **Medical Network**
   - Aetna medical in-network providers can be found by accessing http://www.aetna.com/dse/search?site_id=docfind&langpref=en&tabKey=tab1
     - Individual searching will require selecting Aetna Choice POS II (Open Access) for accurate information about network participation.
   - Temporary network transition of coverage exceptions may be available for individuals who become new members of the Aetna medical benefits plan and are currently being treated by a doctor who is not in the Aetna network.

4. **Covered Prescriptions**
   - After January 1, 2016, complete Rx information can be found by logging into www.aetnanavigator.com. Access to www.aetnanavigator.com requires registration. Registration will not be possible until after January 1, 2016.
   - To help make informed decisions during Annual Enrollment, specific Rx coverage information can be found by visiting http://client.formularynavigator.com/Search.aspx?siteCode=9592642188.

5. **FSA Debit Cards and Processing**
   - Aetna will begin administering the Flexible Spending program on January 1, 2016. Medical FSA claims will be processed through AutoPay and debit cards will not be made available.
     - Aetna will automatically reimburse participants for eligible health care expenses from their health care FSAs after the medical insurance processes your claims. If you have direct deposit, Aetna will deposit the amount into your personal bank account. Otherwise, Aetna will mail the check to you at your home address.
     - Eligible services and expenses received during the 2015 grace period (first two and a half months of 2016) and unsubmitted claims received during calendar year 2015 must be submitted to Aetna for processing after December 31, 2015. A blackout period may apply while reimbursement records are being transferred from United Healthcare to Aetna. All blackout periods will be communicated in advance via Project Notes and/or emails to affected participants.

6. **Pre-Paid Legal**

   Policies will be offered on a family basis. Therefore, the premiums are the same whether you are enrolling yourself or yourself and eligible dependents**.**

7. **Company Discounts**
   - Through the Aetna EAP program, all ITG employees will have access to the Discount Center. New discounts are posted on a regular basis but employees can anticipate receiving company discounts on brand-name products and services, including computers and electronics, cell phone service, theme parks, movie tickets, travel, flowers, and fitness centers.

Enrollment Information

Please remember the following when making your enrollment choices.

- This booklet provides summary information about the Benefits by Design group insurance program.

- ***Annual enrollment is generally the only time you are allowed to change your insurance plan elections***. It is your responsibility to carefully make selections on what policies you would like as well as the dependents that will be covered under each policy. Once Annual Enrollment ends on November 17, 2015, at 12:00 p.m., no changes, including corrections, can be made. Please take some time to carefully review your Annual Enrollment selections to make sure that policies you have selected and the dependents you have listed are correct.

- ***Special Enrollment Periods.*** Once the Annual Enrollment ends, you and your dependents cannot, as a general rule, enroll in any of the plans until the next Annual Enrollment. However, there are exceptions to this rule with respect to the Medical Plan. Federal rules provide that you and your spouse and dependents can enroll in the Medical Plan mid-year if:

  1. You, your spouse, or dependent children lose health insurance coverage or coverage under a group health plan;
  2. You acquire a new dependent (including a spouse) through marriage, birth, adoption, or placement for adoption;
  3. You, your spouse, or dependent children lose coverage under Medicaid or a State Children's Health Insurance Program; or
  4. You, your spouse, or dependent child become eligible for premium assistance under Medicaid or a State Children's Insurance Program.

  If one of these events occurs, you must notify the Benefits Office in writing within 30 days, or 60 days in the case of a birth of a new dependent, if you want to enroll yourself and/or your dependents (including your spouse) in the Medical Plan. If you do not notify the Benefits Office in a timely manner, you will not be able to enroll in the Medical Plan mid-year and will have to wait until the next Annual Enrollment to join the Medical Plan.

- Contributions for life insurance for employees and their spouses are calculated using age-rated premium schedules. Since contributions for these coverages are dependent on your age as well as your coverage amount, your premiums increase automatically if you have a birthday that causes you to move into a new premium age band. Please refer to the age-rated premium schedule included in the Life Insurance section of this booklet to determine the effect of your next birthday on your contributions for employee and spousal life insurance.

- The AMWTP cafeteria plan requires you to make a new Flexible Spending Account election each year in order to continue a Flexible Spending Account. The default election for Flexible Spending Accounts is zero.

- If you are electing Voluntary Life or Spouse Life for the first time, approval is needed from the insurance provider. This is also true if you are increasing your current level of coverage for these policies. It is your responsibility to complete the application and provide it to the insurance provider for approval. CIGNA provides Voluntary Life and Spouse Life, and the application for these policies will be mailed to your home address. As part of the application process you may be required to receive a medical examination at your own expense. Premiums for these policies will not be deducted from your paycheck until official approval is received by the HR Benefits Office from the insurance provider.

AMWTP Cafeteria Plan

AMWTP sponsors a cafeteria plan that allows eligible employees to pick and choose among various plans and to pay for their portion of the premiums on a pre-tax basis. This means that the amount the employee pays for premiums on a pre-tax basis under the AMWTP cafeteria plan is not subject to federal and state income taxes or Social Security taxes. According to IRS rules, once an employee starts making pre-tax salary deferrals under a cafeteria plan, that employee cannot change the amount of those salary deferrals until the first day of the next plan year (i.e., January 1). However, you may modify (begin, end, or change) the amount of your pre-tax salary deferrals under the AMWTP cafeteria plan mid-year if one of these events, called a Qualified Status Change, occurs:

1. Marriage/Divorce or Legal Separation
2. Birth or Adoption
3. Death
4. A change in the employee status of you or your dependents (including your spouse) that impacts your rights or the dependent's right under a group health plan
5. Qualified Court Ordered Child Support
6. Your dependents' (including your spouse's) employer's plan has an open enrollment period
7. Entitlement or loss of entitlement to Medicare or Medicaid
8. The commencement or termination of an unpaid leave of absence (including leave under the Family and Medical Leave Act).

If you experience a Qualified Status Change you must notify the Benefits Office by completing a Qualified Status Change Form within 30 days of the event. The Qualified Status Change Form is located on the HR/Benefits section of the HR homepage. If you submit a properly completed Qualified Status Change Form in a timely manner, you will be able to modify (begin, end, or change) your pre-tax salary deferrals under the AMWTP cafeteria plan mid-year. Note that the Qualified Status Change Form does not alter or govern the rules applicable to the various benefit plans. The Qualified Status Change Form only allows you to modify your pre-tax salary deferrals under the AMWTP cafeteria plan mid-year.

In addition, if there is an insignificant change in the cost of the Benefit Options you select, your pre-tax salary deferrals will automatically be adjusted to reflect the new cost. If there is a significant change in the cost of a Benefit Option you may have the right to add or drop that Benefit Option.

Even with a Qualified Status Change, you generally will not be able to change your plan elections between annual enrollment periods (including your plan elections for medical, dental, vision buy-up, life insurance, etc.). For example, if you divorce during a plan year, you could change your medical coverage level from "employee and spouse" to "employee only;" however, you would not be allowed to change your medical plan choice from Plan B to Plan C.

Except in the case of a birth or adoption of a child, the enrollment change needed due to the Qualified Status Change Form being submitted will be effective the Monday after the form is received. In the case of birth or adoption, the change will be effective on the date of birth or adoption. Missed premiums due to the retroactive effective date will be deducted from the first administratively possible pay check.

Note that the AMWTP cafeteria plan only allows you to pay your share of the benefits you select on a pre-tax basis. You still must qualify for each Benefit Option you select. You also should note that the AMWTP cafeteria plan only applies to certain Benefit Options. That is, you can only pay for some of the Benefit Options on a pre-tax basis under the AMWTP cafeteria plan. Other Benefits Options must be paid on a post-tax basis.

Medical Plans

Summary of Medical Plan Benefits

Medical plan benefits will be administered by Aetna effective January 1, 2016. The following table summarizes the medical plan benefit levels for general medical, mental health, routine eye examination, and prescription drug services. This table is provided as a brief overview of your benefits.

2016 Medical Plan Features	**Plan A**	**Plan B**	**Plan C/HRA**
Co-Pay	**In/Out**	**In/Out**	**In/Out**
Primary Care Physicians	$25/Deductible	$25/Deductible	
Specialists	$40/Deductible	$40/Deductible	
Chiropractic	$40/Deductible	$40/Deductible	
Annual Deductible	**In/Out**	**In/Out**	**In/Out**
Per Person	$500/$1,000	$750/$1,500	$1,250/$2,500
Per Family of 2	$1,000/$2,000	$1,500/$3,000	$2,500/$5,000
Per Family of 3 or more	$1,250/$2,500	$1,875/$3,750	$3,125/$6,250
Deductible Waived	**In/Out**	**In/Out**	**In/Out**
Routine Physician Visit	Yes/No	Yes/No	No/No
Physicals	Yes/No	Yes/No	Yes/No
Cancer Screening Office Visits	Yes/No	Yes/No	Yes/No
Inpatient Hospital	No/No	No/No	No/No
Surgery	No/No	No/No	No/No
Accidental Injury/ Emergency Room	No/No	No/No	No/No
Hospice Care	No/No	No/No	No/No
% Plan Pays After Deductible	80%/60%	80%/60%	80%/60%
Maximum You Pay Each Calendar Year Before Plan Pays 100% (including deductible)	**In/Out**	**In/Out**	**In/Out**
Per Person	$2000/$4,000	$3,000/$6,000	$3,000/$6,000
Per Family	$4,000/$8,000	$6,000/$12,000	$6,000/$12,000
Vision Services			
Deductible	N/A	N/A	NA
Routine Eye Exam (In-Network)	$10 copay	$10 copay	20% after deductible
Routine Eye Exam (Out-of-Network)	40% after deductible	40% after deductible	40% after deductible
Mental Health Services			
Please refer to the Medical Plan Summary. Mental Health services will be processed in parity to other medical services.			
Prescription Drug Copayments			
Retail Drug Card Program			
Co-Insurance Percentage	20%	20%	20%
(Subject to min/max amts)	Min/Max	Min/Max	Min/Max
Generic (Tier 1)	$10/$30	$10/$30	$10/$30
Preferred Formulary (Tier 2)	$20/$60	$20/$60	$20/$60
Non-Preferred Brand (Tier 3)	$40/$120	$40/$120	$40/$120
Regular Mail Order Program Co-pay (90-day supply) / Specialty Pharmacy Program Co-pay (30-day supply)			
Tier 4	$50	$50	$50
Tier 5	$80	$80	$80

How Medical Plan C Works (HRA)

Plan C is a deductible plan with a Health Reimbursement Account (HRA). An HRA rewards you for being good consumers of your health care by allowing unused funds in the HRA to be rolled over from year to year. (See the example below.) This promotes individual responsibility for medical expenses and encourages active participation in medical care decisions.

An HRA is an employer funded account which covers your out-of-pocket health care for medical and mental health up to the fund balance. Each year, funds are allocated to your HRA account equal to half of the deductible. The deductible varies by coverage type (i.e., employee only, employee and spouse, employee and children, or employee and family). If through your effective management of the HRA, funds are not depleted by year end, unused balances left in your HRA will be rolled over from year to year. Fund balances cannot be cashed out or used for non-medical expenses even when you terminate. Examples of how Plan C works and how it is beneficial over time are shown below.

Plan C has six parts: the Fund (HRA), your deductible responsibility, the co-insurance/cost sharing, full coverage, preventive care, and prescription drugs.

1. **The Fund** (Annual Fund: $625 employee only, $1,250 family of 2, $1,562.50 family of 3 or more)
    - At the start of the year, AMWTP will provide a fund (HRA) to help you pay for eligible medical expenses.
    - The expenses paid by the Fund apply toward your deductible.
    - As you incur eligible expenses, the Fund automatically begins to pay for these eligible expenses. For example, for employee only coverage the Fund pays the first $625 of your $1,250 deductible.
    - The balance left in your Fund at the end of the year is rolled over to next year's account.
    - With careful budgeting and wise health care decisions, you can build savings for future health care expenses.
2. **Your In-Network Deductible Responsibility** (Annual Deductible: $1,250 employee only, $2,500 family of two, $3,125 family of three or more.)
    - The amount paid by the Fund applies toward reducing the amount of the deductible that is your responsibility.
    - Once your Fund amount is spent, you are responsible for paying 100 percent of any remaining eligible charges until your deductible is satisfied.
3. **Co-Insurance – Cost Sharing** (Your In-Network Co-insurance: 20%)
    - Once you have met the deductible, you begin paying co-insurance, which is a percent of eligible charges.
    - The Plan pays 80% of eligible in-network charges and 60% of eligible out-of-network charges.
4. **Full Coverage In-Network** (Out-of-pocket maximum **including** the deductible: $3,000 employee only, $6,000 family of 2 or more)
    - Once you reach your out-of-pocket limit, the plan pays 100% of eligible expenses for the remainder of the calendar year.
5. **Preventive Care**
    - Preventive care, such as annual physicals and cancer screenings, are covered at 100% when you use an in-network provider and are not counted against the Fund or your deductible. Preventative care is not covered if you use an out-of-network provider.
6. **Prescription Drugs**
    - The cost of prescription drugs is separate from the HRA funds. You pay co-insurance or co-pays, just like Plan A and Plan B.

Example: Employee only coverage
Annual HRA Amount: $625
Annual Deductible Amount: $1,250

1. The Fund HRA (Company) pays 100% of expenses up to $625	2. Employee Deductible Responsibility Employee pays 100% of deductible (less expenses paid by the HRA)	Total Deductible Level	3. Co-Insurance/ Cost Sharing Employee pays 20% in-network 60% out-of-network	Out-of-pocket maximum level	4. Full coverage Plan pays 100% after out-of-pocket is met
$625	+ $625 =	$1,250		$3,000	

5. **Preventive Care:** Covered at 100% (in network).
6. **Prescription Drugs:** Employee pays co-insurance or co-pay. Co-insurance and co-pay for prescription drugs are not subject to deductible.

How Plan C becomes more beneficial to you over time.

	Year 1	Year 2	Year 3
HRA Fund			
Annual Fund	$625	$625	$625
Fund Rollover from Prior Year	NA	$275	$575
Total Fund	$625	$900	$1,200
Expenses Paid From Fund	$350	$325	$1,200
Remaining Fund Balance	**$275**	**$575**	**$0**
The Deductible			
Beginning Annual Deductible	$1,250	$1,250	$1,250
HRA Payment Subtracted from the Deductible	$350	$325	$1,200
Remaining Deductible Balance	$900	$925	$50
Amount Employee Pays to Meet the Deductible	$0	$0	$50
Co-insurance			
Remaining Expenses (after deductible)	$0	$0	$3,000
Amount Employee Pays in Co-insurance (20% of remaining expenses)	$0	$0	$600
Amount the Plan pays in Co-insurance (80% of remaining expenses)	$0	$0	$2,400
Amount Rolled Over to Next Year's Fund Balance	**$275**	**$575**	**$0**

Year One

- The first year was one of good health for the employee. Covered medical expenses totaled $350.
- Costs were paid through the HRA; the HRA and the deductible were reduced by $350.
- In year one, covered services were paid in full through the HRA. The employee paid $0 out of pocket and the $275 HRA balance rolled over to the next year.

Year Two

- The second year was another one of good health for the employee. Covered medical expenses totaled $325.
- Costs were paid through the HRA; the HRA, deductible, and out-of-pocket maximum, were reduced by $325.
- In year two, covered services were again paid in full through the HRA. The employee paid $0 out of pocket, and the HRA balance of $575 rolled over to the next year.

Year Three

- In the third year, the employee incurred higher medical costs. Covered expenses totaled $4,250.
- The HRA paid the first $1,200, leaving a HRA balance of $0 and a deductible balance of $50. Since the deductible was not met, the employee paid the $50 out-of-pocket to meet the deductible.
- Remaining unpaid expenses totaled $3,000. With the HRA fund exhausted and the deductible met, the cost sharing coverage begins.
- The employee visited an in-network provider, so the employee paid 20% ($600) and the plan paid 80% ($2,400).
- The employee paid a total of $650 ($50 to meet the deductible and $600 in co-insurance).
- The plan paid a total of $3,600 ($1,200 from the HRA and $2,400 for co-insurance).
- There is no HRA balance remaining, so year four begins with a $625 HRA balance.

Retiree Medical

You are eligible for retiree medical benefits if you meet all of the following criteria:

1. You are at least fifty-five (55) years of age **and** you have at least five (5) years of recognized service at the time your employment terminates.
2. You are currently enrolled in one of the medical insurance plans sponsored by Idaho Treatment Group, LLC.
3. You are not eligible for similar medical coverage either through your spouse, through another employer or through Medicare.

If eligible for retiree medical, you must enroll in retiree medical at the time you retire. You may continue your existing medical coverage for you and your dependents that are currently enrolled. The coverage you choose will terminate if at any time in the future you should fail to make the required contributions **or** if you become eligible for similar medical coverage through another employer **or** through Medicare. You will be required to certify on an annual basis the eligibility for your continued participation and for your dependents. The company reserves the right to change, modify, or discontinue the benefits programs and to increase premiums without notice, to the extent permitted by law.

Your personal participation will end when you become eligible for Medicare or eligible for similar coverage elsewhere. Dependents can continue until they are no longer eligible as defined under the Plan or until they attain eligibility for Medicare.

Prescription Drugs

Prescription drug coverage is administrated by Aetna Pharmacy Management. Detailed information about prescription coverage can be found by visiting the Aetna Pharmacy Management website at https://www.aetna.com/individuals-families/pharmacy.html. This website contains information on network pharmacies and a complete list of prescriptions and their current tier categories. Detailed information about prescriptions specific to you, including costs, can be found by visiting www.aetnanavigator.com.

Retail Pharmacy Program
Aetna has a nation-wide network of pharmacies that is available to all medical plan participants. By using a participating pharmacy to obtain a maximum 30-day supply under the retail drug card program, you will pay only the applicable co-insurance for the medication being dispensed. Additionally, you will not have to file any claims since all of the paperwork will be handled between the pharmacy and Aetna.

Mail Order Prescription Drug Program
Participants using medications for long-term medical conditions will generally find the mail order program to be a cost effective alternative to the retail pharmacy. The mail order program allows for up to a 90-day supply of medication to be dispensed. You will pay the applicable co-pay for each prescription. Medications purchased through the AetnaRx Home Delivery Pharmacy are sent directly to your home, allowing you to avoid a trip to the local pharmacy each month.

Specialty Pharmacy Program
The Specialty Pharmacy program – Aetna Specialty CareRX – offers participants using certain specialty medications (that are not available through the regular mail order program) to receive assistance in managing their medical conditions. Interaction with licensed pharmaceutical specialists will ensure your specialty medication is being used correctly to provide you with the utmost benefit. Up to a 30-day supply of specialty medications can be dispensed to you through the specialty pharmacy. You will pay the applicable co-pay for each prescription and refill ordered through this program.

Mental Health and Substance Abuse Services

Medical plan benefits for mental health care and substance abuse treatment services are administered through the Aetna Behavioral Health Condition Management program. This behavioral health program includes personal case management for each mental health or substance abuse treatment plan, thereby providing assurance that the treatment received is consistent with individual patient needs.

You may contact Aetna Behavioral Health Condition Management at 1-800-424-4660. With this confidential condition management program, you have a support system. You get a team of people involved in your progress – doctors, nurses, psychologists, and social workers. They will work with your care team to set up the best treatment for you. *Please be sure to contact Aetna to make certain that your provider is a member of the Aetna network.*

Preventative Care Summary

Preventing disease and detecting health issues at an early stage, if they occur, are important to living a healthy life. Following recommended guidelines, along with the advice of your doctor, may help you stay healthy. Preventative services are subject to frequency limitations. For example an adult is eligible for an annual preventative office visit. If you received a preventative office visit on May 1, 2015 a preventative office visit is not a covered health service again until May 2, 2016.

Well-Child Care through age 22
• Seven visits 0-12 months • Three visits 13-24 months • Annual visits age 24 months through age 22 • Annual pap smear and pelvic exam, as appropriate by age • Lead level testing, for children at risk for exposure • Immunizations: Hepatitis A, Hepatitis B, Diphtheria, Tetanus, Pertussis (DtaP), Haemophilus Influenza type B, Polio, Pneumococcal conjugate, Varicella, Measles, Mumps, Rubella, HPV, and annual flu shot • Labs, pathology, chest x-ray, and EKG (when performed as preventive care)

In addition to an annual physical, screenings and vaccinations may be applicable for adults. Below are some examples of common Preventative Care services. The colored lines indicate the typical age recommendation for the service. Preventative Care items in green are applicable for men and women, items in orange or Preventative Care for women.

Obesity Screening										
18	25	30	35	40	45	50	55	60	65	70
Recommended weight assessment at each preventive visit.										

Blood Pressure										
18	25	30	35	40	45	50	55	60	65	70
Recommended blood pressure assessment at each preventive visit.										

Cardiovascular Disease Aspirin Use Counseling										
18	25	30	35	40	45	50	55	60	65	70
Recommended for certain patients age 45 and up to obtain counseling, from a primary care physician, on the use of aspirin in the prevention of cardiovascular disease. For those at high risk for heart disease, discuss aspirin and low risk alternatives with your physician.										
Diabetes Screening										
18	25	30	35	40	45	50	55	60	65	70
Recommended for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.										

Cholesterol (Lipid) Test										
18	25	30	35	40	45	50	55	60	65	70
Screening recommended for all men age 35 and up; men age 20 through 34, and women age 20 and up if at increased risk of coronary heart disease.										

Colorectal Cancer Screening										
18	25	30	35	40	45	50	55	60	65	70
Routine colorectal cancer screening recommended beginning at 50 years, high risk persons should be screened at younger ages and more frequently than persons at standard risk. Speak with your physician regarding screening methods and appropriate screening intervals.										

Influenza Vaccine										
18	25	30	35	40	45	50	55	60	65	70
One dose annually as directed by your physician.										

Cervical Cancer Screening (Pap Smear)										
18	25	30	35	40	45	50	55	60	65	70
The USPSTF recommends screening in women age 21 to 65 with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papilloma virus (HPV) testing every 5 years.										

Mammography										
18	25	30	35	40	45	50	55	60	65	70
Screening mammography recommended for all adult women of standard risk every one to two years beginning at age 40 or as directed by your physician. Women at defined high risk should be screened early. Consult with your physician regarding breast cancer prevention alternatives with low risk of adverse effects.										

Please be aware that when receiving preventative care and an abnormality is found and additional testing is required, the additional testing claims will be processed and paid as diagnostic not preventative. For example, if you had an in-network colonoscopy and no polyps are found the claim will be processed and paid at 100% subject to plan rules (i.e. network status, age and frequency limitations). If you receive an in-network colonoscopy and polyps are found, the colonoscopy would be processed and paid as preventative. The removal and testing of the polyps will be processed and paid as diagnostic and will be subject to plan deductibles and co-insurance.

Routine Eye Exam

Physician services for routine eye exams are administered and managed by Aetna Vision through a national network. A comprehensive annual eye exam with an Aetna Vision network provider costs a copayment of $10.00 per exam. Annual eye exams are only considered a covered health service once every rolling 12 months. For example, if you received an eye exam on April 2, 2015 you are not eligible for coverage of an eye exam under your Medical Plan until April 3, 2016. Participating providers will file the claim with Aetna Vision for you.

If you use an out-of-network provider, you pay for the services up front and then submit a claim form to receive reimbursement. Claim forms are located at www.aetnavision.com or by calling customer services at 877-973-3238. Submit the completed claim form with receipts to Aetna, P. O. Box 8504, Mason, OH 45040-7111. Use of an out-of-network provider will likely result in a higher out-of-pocket cost. Network availability can be ch3ecked by contacting Aetna Vision at 877-973-3238 or by visiting their website at www.aetnavision.com.

Network Information

The most current Network provider information may be obtained by calling Aetna at 877-204-9186, or by going directly to the Aetna web page at www.aetna.com.

Typically, you will receive reimbursement at the in-network level of benefits for covered services you obtain from in-network providers; however, there are some situations when you may also receive the in-network level of reimbursement for services obtained from non-network providers. Generally, this is possible only in those situations where you and/or your dependents:

- Obtain services due to an urgent illness or sudden medical condition that occurs when you are out-of-network.
- Obtain emergency medical services for the initial treatment of a critical or life-threatening medical situation.

In these situations, reimbursement for a non-participating provider will be made at the in-network schedule of benefits, subject to normal plan rules regarding medical necessity, reasonable and customary limitations, etc. You must notify Aetna within 24 hours if emergency services are received from an out-of-network provider in order for the claim to be paid as in-network.

Remember, it is your responsibility to verify that the providers you use are members of the Aetna Provider Network. Except as noted above, services received from non-network providers will be reimbursed at the lower out-of-network schedule of benefits. This is true even if you are referred to an out-of-network provider by an in-network provider.

Aetnanavigator.com

Aetna offers a personalized comprehensive website. On www.aetnanavigator.com you can get a copy of your ID card, check your benefit coverage, and monitor the status of your plan deductibles and out-of-pocket limits. You can find doctors and hospitals in your network, evaluate hospitals on quality and patient safety, and get driving directions and maps. You can see your medical claims and print copies for your records. You can estimate the cost of a treatment or procedure beforehand and find the information you need to make health care decisions. www.aetnanavigator.com also offers access to discount programs and includes easy to read health topics.

To register for aetnanavigator.com

1. Visit www.aetnanavigator.com
2. Select REGISTER NOW
3. Type in the required information (you will need your current medical ID card)

Eligible Dependents

It is the employee's responsibility to ensure that the dependents they list under their medical policy are eligible for coverage. The employee's legal spouse and/or dependent children are considered eligible for coverage under the AMWTP Medical Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the employee or the spouse of the employee.

A dependent child must also be under the age of 26 to be considered eligible.

A dependent child also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order.

An employee is subject to disciplinary action up to and including termination for enrolling ineligible dependents under the medical plan. Such actions are considered insurance fraud. Additionally, the Plan Administrator may rescind coverage if there has been fraud or an intentional misrepresentation of a material fact. The Plan Administrator will provide a thirty day advanced written notice of the recession and the individual will have an opportunity to appeal the Plan Administrator's decision. The employee also must reimburse the medical plan for any Benefits that were paid for an individual at a time when they did not satisfy these conditions.

Notification Requirements

Prior notification is required before you receive certain covered health services. In general, network providers are responsible for notifying Aetna before they provide these services to you. However, it is in your best interest to confirm with your in network provider that this notification has been made.

When you choose to receive certain covered health services from non-network providers, you are responsible for notifying Aetna before you receive these covered health services.

Failure to make required notification to Aetna will result in a reduced benefit for services received.

Women's Health and Cancer Rights Act

The *Women's Health and Cancer Rights Act* is a federal law that became effective October 21, 1998. This law requires group health plans that provide coverage for medically necessary mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

This law mandates that a covered member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy will receive coverage for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in accordance with normal plan provisions and will generally be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

The medical plan offered to employees of AMWTP is in compliance with the *Women's Health and Cancer Rights Act*. If you have any questions about the plan's coverage of mastectomies and related reconstructive surgery, please contact Aetna at 877-204-9186.

Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection and Affordable Care Act

AMWTP believes this medical plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your AMWTP Medical Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 208-557-0930. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

24 Hour Nurse Line

A 24 hour nurse line called Informed Health Line is available to employees enrolled in the medical plan. This nurse line offers information and resources that can help you and your family identify and resolve problems affecting emotional and physical health. Informed Health Line is staffed by a team of registered nurses and master's-level counselors. The nurse line can answer questions ranging from treating a burn to the possible side effects of medications - ***at no cost to you.*** To access Informed Health Line, call 1-800-556-1555.

Employee Assistance Program

Help in dealing with professional or personal stressors is just a phone call away. The Employee Assistance Program (EAP) is available not only to all ITG employees but their dependents as well and is **completely anonymous**.

Contact the Aetna Employee Assistance Hotline at 1-888-238-6232 available 24 hours a day, seven days a week. The on-call counselor will perform an initial assessment then refer you to a local counselor.

You may also find EAP resources online at www.resourcesforliving.com. Log in using the user name: MYITGEAP and password: EAP.

You will receive up to three visits with a local counselor absolutely free. After three visits, additional treatment through the EAP qualifies for coverage under our Medical Plan. Normal deductibles and co-pays will apply.

Common Medical Plan Terms

Annual Deductible – the amount you must pay for covered health services in a calendar year before the insurance plan will begin paying for benefits in that calendar year. The actual amount that is applied to the annual deductible is calculated on the basis of eligible expenses. When enrolled in Medical Plan A or Medical Plan B, co-payments for routine office visits do not apply toward your annual deductible. The annual deductible does not include any amount that exceeds Eligible Expenses. See the definition of eligible expenses below.

Benefits – your right to payment for covered health services that are available under the medical insurance plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the medical insurance plan.

Co-payment – the charge you are required to pay for certain covered health services. A copayment is a set dollar amount per visit for in-network office visits received when enrolled in Medical Plan A and Medical Plan B and when receiving benefits under the routine eye exam portion of the medical insurance plan.

Co-Insurance – the charges you are required to pay for certain covered health services. Co-insurance is a percentage of the eligible expenses that are your responsibility once the deductible is met. Co-insurance applies toward your out-of-pocket maximum.

Eligible Dependent **–** the employee's legal spouse or dependent child are considered eligible for coverage under the AMWTP Medical Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the employee or the spouse of the employee.

A dependent child must also be under the age of 26 to be considered eligible.

Eligible Expenses – for covered health services, eligible expenses are based on either of the following:

- When covered health services are received from in-network providers, eligible expenses are the contracted fee(s) with that provider.
- When covered health services are received from non-network providers as a result of an emergency or as otherwise arranged through Aetna, eligible expenses are billed charges unless a lower amount is negotiated.

For non-network benefits, eligible expenses are based on either of the following:

- When covered health services are received from non-network, eligible expenses are determined at Aetna discretion based on:

- Available data resources of competitive fees in that geographic area
- Fee(s) that are negotiated with the provider
- 50% of billed charge

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with Aetna or with an Aetna affiliate to participate in the Aetna network.

A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be a network provider for only some of Aetna's products. In this case, the provider will be a network provider for the covered health services and products included in the participation agreement, and a non-network provider for other covered health services and products. The participation status of providers will change from time to time.

Network Benefits – benefits for covered health services that are provided by a network provider, network facility, or other network provider.

Non-Network Benefits – benefits for covered health services that are provided by a non-network physician, non-network facility, or other non-network provider.

Out-of-Pocket Maximum – if you use network benefits and non-network benefits, two separate out-of-pocket maximums apply. Once you reach the out-of-pocket maximum for network benefits, benefits for those covered health services are payable at 100% of eligible expenses during the rest of that calendar year. The amount a covered individual pays toward their deductible will also apply toward their out-of-pocket maximum. Co-payments for routine office visits when enrolled in Medical Plan A and Medical Plan B do not apply toward your out-of-pocket maximum.

Medical Plan Contributions

The 2016 bi-weekly employee contribution rates for the Benefits by Design medical plan options are shown below.

Bi-Weekly Employee Contributions	**Plan A**	**Plan B**	**Plan C/ HRA**	**Opt Out***
Employee Only	$88.31	$60.45	$60.45	($23.08)*
Employee, Spouse, and Children	$253.75	174.16	174.16	($23.08)*
Employee and Children (No Spouse)	$165.63	$113.89	$113.89	($23.08)*
Employee and Spouse (No Children)	$176.36	$120.67	$120.67	($23.08)*

*** The opt-out credit is available only if you are not covered in the AMWTP medical plan as a dependent of your spouse.** Contributions for your medical coverage are made on a pre-tax basis.

For your information, below you will find the bi-weekly cost the company pays for each medical plan option. This cost is in addition to the premiums paid by employees.

Bi-Weekly Company Contributions	**Plan A**	**Plan B**	**Plan C/ HRA**
Employee Only	$266.67	$262.47	$262.47
Employee, Spouse, and Children	$773.65	$760.47	$760.47
Employee and Children (No Spouse)	$508.66	$499.51	$499.51
Employee and Spouse (No Children)	$531.68	$523.44	$523.44

Dental Plans

Dental Plan A, Plan B, and Plan C are fully insured by Aetna. The table that follows includes a summary of the basic provisions of Dental Plans A, Plan B, and Plan C. Please note that the only difference between Dental Plan A and Dental Plan B is orthodontic services. Dental Plan A provides orthodontic coverage while Plan B does not.

Plan Features	Plan A	Plan B	Plan C
Annual Deductible			
Per Person	$25	$25	$50
Per Family	$75	$75	$150
Plan Pays For:			
Preventive (No Deductible)	100%	100%	100%
Diagnostic Services (No Deductible)	100%	100%	100%
Minor Restorative Services	80%	80%	50%
Major Restorative Services and Prosthodontic Services	50%	50%	50%
Orthodontic	50%	NA	NA
Maximum Benefit Per Person Per Year	$1,500	$1,500	$750
Orthodontic Lifetime Benefit Maximum	$1,500	NA	NA

To avoid unanticipated out-of-pocket costs for dental services, you may wish to ask your dentist to submit a predetermination of benefits if your dental treatment involves services of $100 or more, or if you will be receiving major prosthodontic or restorative services (such as a crown). A statement will be sent to your dentist estimating the amount that Aetna will pay for the service and the amount that will be left for you to pay.

Dependent Eligibility

The employee's legal spouse or dependent child is considered eligible for coverage under the AMWTP Dental Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the employee or the spouse of the employee.

A dependent child must also be under the age of 26 to be considered eligible.

Dental Plan Contributions

Shown below are the 2016 bi-weekly contribution rates for dental coverage for all plans.

Bi- Weekly Employee Contributions	**Plan A**	**Plan B**	**Plan C**
Employee Only	$12.01	$10.05	$3.19
Employee, Spouse, and Children	$34.27	$28.02	$7.93
Employee and Children (no spouse)	$21.79	$18.00	$4.97
Employee and Spouse (no children)	$23.43	$19.48	$5.67
Opt Out Credit*	($2.31)*	($2.31)*	($2.31)*

*** The opt-out credit is available only if you are not covered in the AMWTP dental plan as a dependent of your spouse.**

Contributions for your dental coverage are withheld on a pre-tax basis.

For your information, below you will find the bi-weekly cost the company pays for each dental plan option. This cost is in addition to the premiums paid by employees.

Bi-Weekly Company Contributions	**Plan A**	**Plan B**	**Plan C/ HRA**
Employee Only	$12.92	$13.64	$15.74
Employee, Spouse, and Children	$43.02	$45.44	$50.78
Employee and Children (No Spouse)	$25.57	$27.02	$31.01
Employee and Spouse (No Children)	$26.44	$27.92	$32.21

Optional Vision Plan

The Benefits by Design optional vision plan is insured by Aetna. After satisfying the $20 co-pay, the plan will cover either contact lenses or one pair of glasses, generally each calendar year. ***Please note that frames will be covered only once every two years, and that contact lenses will count as a frame for this purpose.***

Aetna utilizes the Aetna Select Vision network. Although you are not limited to participating Aetna Vision providers, the plan provides a higher level of coverage when you obtain your services from these doctors. Information about which providers are included in the Aetna Select Vision network may be obtained by calling 877-973-3238 or by accessing the Aetna Vision web site at www.aetnavision.com.

The table that follows summarizes the 2016 coverage available through the Optional Vision Plan. Please note that this table is provided only as an overview of your vision benefits.

Benefits	**In Network**	**Out of Network**
Co-pay (per person) for lenses	$20	N/A
Plan pays for:		
Spectacle lenses (each plan year)	100%* after $20 co-pay	Up to $60
Spectacle frames (once every two plan years)	$130 allowance	Up to $65
Medically necessary contact lenses (each plan year)	100%	Up to $200
Elective contact lenses (each plan year)	4 boxes **	Up to $90

** Participants may pay an additional charge for special lens features and/or designer frames. Standard scratch resistant coating is covered in full.*

*** Materials co-pay only on a selection of Aetna Vision covered frames and contact lenses. Other frames will have a $130 retail allowance at retail chain providers or a $65 wholesale allowance on frames with a provider in a private practice. Other contact lenses will have a $130 allowance and cover contact lenses such as toric, gas permeable, and bifocals.*

Dependent Eligibility

The employee's legal spouse or dependent child is considered eligible for coverage under the AMWTP Vision Buy-Up Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the employee or the spouse of the employee.

A dependent child must also be under the age of 26 to be considered eligible.

In previous years, employees electing both medical coverage and vision buy-up coverage were required to cover the same dependents under both plans. Beginning January 1, 2016, this requirement no longer applies. Employees may elect dependent coverage as needed for medical and vision buy-up independent of each other.

Optional Vision Plan Contributions

Bi-Weekly Employee Contributions	Plan
Employee Only	$2.43
Employee, Spouse, and Children	$7.13
Employee and Children (No Spouse)	$4.85
Employee and Spouse (No Children)	$4.61

Contributions for optional vision coverage are withheld on a pre-tax basis.

Life and Accident Insurance

Life Insurance for You

Changes, increases, new enrollment, decreases and dropping of coverage, must be coordinated through CIGNA. CIGNA will be mailing to your home address a packet of information on the policies available to you. Please carefully review the packet. If you desire to make a change in your current coverage level, the appropriate paperwork must be submitted to CIGNA. If you wish to keep your Life Insurance and Voluntary Life (GUL) policies the same as you currently have simply elect the same coverage level during the Annual Enrollment process as you currently have, no additional action on your part is needed.

Life insurance can provide valuable financial protection for you and your family in the event of your death or the death of a family member. The 2016 Benefits by Design program offers six choices of life insurance for you. Idaho Treatment Group provides, at no cost to you, Option 1 listed below. Employees are responsible for Social Security and Medicare taxes for company paid premiums for life insurance policies valued over $50,000. This taxable income is reported to the IRS at the end of the year on your W-2. You can also purchase additional life insurance for you, your dependent spouse, and children. The life insurance program is insured by CIGNA. **All life insurance premiums are paid on an after-tax basis.**

Option	Term Insurance	GUL Insurance	Total Coverage
1	2.25 times salary	N/A	2.25 times salary
2	2.25 times salary	1 times salary	3.25 times salary
3	2.25 times salary	2 times salary	4.25 times salary
4	2.25 times salary	3 times salary	5.25 times salary
5	2.25 times salary	4 times salary	6.25 times salary
6	2.25 times salary	5 times salary	7.25 times salary

Option 1 is paid for by the company at ***no cost to you***. Options 2 through 6 provide additional coverage and are subject to the rate table found below.

The maximum coverage available through this program is $1,500,000, of which no more than $500,000 may be term insurance (provided by the company) and no more than $1,000,000 may be Group Universal Life (GUL or Voluntary Life) insurance (cost for GUL insurance is listed below).

If you participate in the GUL program and purchase life insurance coverage that is more than 2.25 times your salary, you will pay for the additional coverage using the age-rated premiums shown below:

Age	Cost per $1000
Less Than 25	$0.047
age 25-29	$0.047
age 30-34	$0.056
age 35-39	$0.078

Age	Cost per $1000
age 72	$3.248
age 73	$3.594
age 74	$3.983
age 75	$4.421

Age	Cost per $1000
age 40-44	$0.112
age 45-49	$0.232
age 50-54	$0.390
age 55-59	$0.698
age 60-64	$0.966
age 65-69	$1.737
age 70	$2.646
age 71	$2.934

Age	Cost per $1000
age 76	$4.919
age 77	$5.471
age 78	$6.079
age 79	$6.739
age 80	$7.450
age 81	$8.211
age 82	$9.016
age 83	$9.864

To calculate your bi-weekly premium you will need your annual salary rounded to the nearest 1,000, your election amount which is anywhere from 1 to 5, and your age rated premium. The following formula will be used to calculate the bi-weekly premium.

((((Annual Salary x election amount)/1,000) x age rated premium) x 12)/26 = Bi-weekly Voluntary Life (GUL) premium.

The following example is for a person age 47 making $62,000 per year and electing 4 times their salary in Voluntary Life coverage.

((($62,000x4)/1,000) x.232) x12)/26 = $26.56 bi-weekly premium

Please note that your cost for life insurance coverage will automatically change effective the first of the following week if:

- There's a change in your salary,
- Or your monthly rate per $1,000 of coverage changes because of a birthday that causes you to move into a new premium age band.

Contributions for life insurance for employees and their spouses are calculated using age-based premium schedules. Since contributions for these coverages are dependent on your age as well as your coverage amount, your premiums increase automatically if you have a birthday that causes you to move into a new premium age band. Please refer to the age-rated premium schedule above to determine the effect your coming birthday may have on contributions for employee life insurance during 2016. The Benefits by Design plan provisions do not allow for mid-year changes in life insurance coverage, so it is important to make any desired adjustments at this time.

Special Features of Group Universal Life (GUL)

GUL Living Benefit – If you are diagnosed with a terminal illness and are not expected to live longer than six months, you may request a "Living Benefit." Under this provision you may choose to receive, while you are still living, the following amount:

1. Up to 50% of your coverage amount (not in excess of $250,000), plus
2. A portion of your Cash Accumulation Fund Amount. The amount of your Fund Amount available under this option is equal to the percentage of total coverage elected under the above times:
    a. Your total Fund Amount, less
    b. The amount of any outstanding loans and related interest.

When you die, your beneficiary will receive your coverage amount, minus the Living Benefit amount you received.

Cash Accumulation Side Fund – Participants in the GUL program may also participate in a Cash Accumulation Side Fund. This fund will grow on a tax-deferred basis and may be withdrawn or borrowed for any reason. Deposits into the cash accumulation side fund should be coordinated directly with CIGNA.

Please be aware that if you opt out of life insurance coverage for 2016, you will be required to provide acceptable evidence of good health in order to enroll in coverage in a later year. This is also true if you are increasing your coverage level for 2016.

Life Insurance for Your Spouse

Employees will have the opportunity to review and make adjustments in their current level of coverage during Annual Enrollment. Evidence of Insurability application is required for an increase in coverage or new enrollment in coverage.

The options for life insurance on your spouse are 1, 2, or 3 times your annual base salary, or $25,000 subject to the following limitations:

You may not choose more life insurance for your spouse than you choose for yourself.

You may not be covered under the life insurance program as both an employee and a spouse.

You are expected to observe the coverage limitation rules noted above. ***Duplicate or excessive life insurance benefits will not be paid by the insurance company and premiums for such coverage will be refunded only if permitted by the insurance company and if administratively feasible.***

The cost of life insurance on your spouse is determined using the age-rated premium for **your age** (the employee) from the table that follows:

Age	Cost/$1,000
<30	$0.047
30 – 34	$0.056
35 – 39	$0.078
40 – 44	$0.112
45 – 49	$0.232
50 – 54	$0.390
55 – 59	$0.698
60 – 64	$0.966
65 – 69	$1.737
70 +	$3.092

To calculate your bi-weekly premium you will need your annual salary rounded to the nearest 1,000, your election amount which is anywhere from 1 to 5, and your age rated premium. The following formula will be used to calculate the bi-weekly premium.

((((Annual Salary x election amount)/1,000) x age rated premium) x 12)/26 = Bi-weekly Spouse Voluntary Life premium

The following example is for a person age 47 making $62,000 per year and electing 4 times their salary in Spouse Voluntary Life coverage.

((($62,000x4)/1,000) x.232) x12)/26 = $26.56 bi-weekly premium

Please note that contributions for life insurance for employees and their spouses are calculated using age-based premium schedules. Since contributions for these coverages are dependent on **your** age as well as your coverage amount, your premiums increase automatically if you have a birthday that causes you to move into a new premium age band. Please refer to the age-rated premium schedule above to determine the effect your next birthday may have on your contributions for spousal life insurance during 2016.

Please be aware that if you opt out of Spouse Life Insurance coverage for 2016, you will be required to provide acceptable evidence of good health in order to enroll in coverage in a later year. If you are increasing your coverage level or selecting a Spouse Life Insurance policy for the first time for 2016, an application must be approved by CIGNA.

You cannot pay for Spouse Life Insurance on a pre-tax basis under the AMWTP Cafeteria Plan.

Life Insurance for Your Dependent Children

Life insurance for your dependent children aged six months through 18 years (and for children ages 19 to 23 who qualify as wholly dependent full-time students) is available through Benefits by Design in the amounts of $10,000 and $25,000. Proof of insurability is not required to increase the level of life insurance coverage on your dependent children.

If both you and your spouse work for the company, only one of you may elect dependent coverage for your children. Also, you may not carry more life insurance on your children than you carry on yourself. ***You are expected to observe these rules. Duplicate or excessive life insurance benefits will not be paid by the insurance company and premiums for such coverage will be refunded only if permitted by the insurance company and is administratively feasible.***

Shown below are the 2016 bi-weekly contribution rates for Dependent Children Life Insurance coverage.

<u>Bi-Weekly Employee Contribution</u>

$10,000 Policy	$0.37
$25,000 Policy	$0.92

The cost is the same regardless of the number of children and is post-tax. That is, you cannot pay for Dependent Children Life Insurance on a pre-tax basis under the AMWTP Cafeteria Plan.

Accident Insurance

The Benefits by Design Accidental Death and Dismemberment (AD&D) insurance plan is administered by CIGNA.

AD&D insurance provides additional protection for you and your family in the event of accidental injury or death. The AD&D insurance plan will pay your beneficiary the full amount of the benefit you choose if you die as the result of an accident. A percentage of the full amount will be paid if you sustain specific injuries (such as the loss of a hand, eye, etc.) in an accident; a lesser amount will be paid for the accidental death or injury of a covered family member. You would be the beneficiary for these payments.

The Company provides all regular full-time employees with AD&D insurance equal to one times their base annual salary. Through Benefits by Design you may purchase additional AD&D coverage in multiples of your salary (from one times your salary to 10 times your salary) to a maximum coverage level of $750,000. You may also elect Family AD&D coverage. This plan covers you, your legal spouse and dependent children (dependent children aged six months through 18 years, and for children ages 19 and 20 who qualify as wholly dependent full-time students). When electing Family AD&D coverage there are three options:

1. Family AD&D. When electing this option you are covering yourself and both your legal spouse and dependent children. With this option your spouse is eligible for coverage valued at 50% of your coverage level and your dependent children are eligible for 10%.

2. Employee and Spouse AD&D. When electing this option you are covering yourself and your legal spouse. With this option your spouse is eligible for coverage valued at 60% of your coverage level.

3. Employee and Child/Children AD&D. When electing this option you are covering yourself and your dependent child/children. With this option your child/children is eligible for coverage valued at 15% of your coverage level. Covered family members are eligible for a portion of the total value of the policy elected.

Family AD&D coverage is also available in multiples of your salary up to 10 times or $750,000, whichever is less.

Beneficiary Designation

Be sure to name beneficiaries for your plan account. Properly designating beneficiaries ensures that when you die, your hard-earned savings are distributed directly to your loved ones according to your wishes. If you are legally married and name a non-spouse as a primary beneficiary, the Beneficiary Designation form will need to be signed by your legal spouse and notarized. Until the notarized form is received, your Beneficiary Designation remains unchanged.

AD&D Plan Contributions

Shown below are the 2016 bi-weekly contribution rates for AD&D beyond what the Company provides. Contributions for you AD&D coverages are withheld on a pre-tax basis.

Bi-Weekly Employee Contributions	Per $1,000 of Coverage
Employee Only	$0.029
Employee, Spouse, and Children	$0.052

To calculate your bi-weekly premium you will need your annual salary rounded to the nearest 1,000, your election amount which is anywhere from 1 to 10, and your rate which is either $0.029 or $0.052 depending on which policy you elect. The following formula will be used to calculate the bi-weekly premium:

((((Annual Salary x Election Amount)/1,000) x Rate) x 12) / 26 = Bi-weekly Voluntary AD&D premium

The following example is for a person making $62,000 per year and electing 4 times their salary in Employee + Family AD&D coverage.

(((($62,000 x 4)/1,000) x 0.052) x 12) / 26 = $5.928 bi-weekly premium

Contributions for your voluntary AD&D coverage are withheld on a pre-tax basis.

Disability Insurance

Short-Term Disability Insurance

The Benefits by Design Short-Term Disability (STD) plan can help protect you against loss of income in the event of accident or illness. The STD plan is fully insured by CIGNA. Employees who participate in this plan are eligible to receive STD wage reimbursement benefits beginning on the eighth consecutive calendar day. There are two levels of STD coverage, as follows:

- **STD Basic Coverage (Company-paid STD coverage for all regular full-time employees).** Benefits available under the company-paid option are equal to the lesser of (1) 60% of your base weekly salary, or (2) $600 per week.

- **STD Buy-Up (Employee-paid additional coverage for employees who earn more than $52,000 per year).** Employees who earn more than $52,000 per year are able to purchase additional STD coverage at their own expense. These employees are not fully protected by the company-paid option because 60% of their base weekly salary is greater than the $600 cap on weekly STD benefits. Employees who take advantage of the STD buy-up option will be eligible for STD wage reimbursement benefits equal to the lesser of (1) 60% of base weekly salary, or (2) $1,200 per week.

  If you are enrolling in STD Buy-Up for the first time in 2016, an Evidence of Insurability application must be approved by CIGNA. Also, any medical issue occurring in the three months prior to the start of coverage will not be eligible for disability payments under the STD Buy-Up plan for the first 12 months of coverage.

In the case of an accident or illness, a seven calendar day waiting period will be required before an approved Short Term Disability claim is payable. Employees are responsible to cover the time away from work during this seven calendar day period with Personal Leave.

To initiate a STD claim, contact CIGNA at 1-800-362-4462.

CIGNA will make all assessments of disability for purposes of determining eligibility for STD benefits. This assessment includes determining an "end of disability" date**.** Employees are required to contact HR Benefits within 24 hours of their approved disability ending or the issuing of a denial of an extension to coordinate a return to work. A return to work must occur within three work days of the end of an approved disability claim or the issuing of a denial of an extension. **Failure to return to work within the allotted three work days will constitute a voluntary termination of employment.**

Employees who are approved by CIGNA for STD benefits may supplement their insured benefits with either personal leave or STD bank hours to provide a total wage reimbursement equal to (but not in excess of) 100% of base salary.

Employees will receive the basic STD coverage **at no cost.** Employees who purchase additional STD coverage will have a bi-weekly cost equal to $0.218 for each $10 of bi-weekly income between $2,000.00 and $4,000.00. Your cost for STD buy-up coverage will automatically change if there is an increase in your salary. The chart below illustrates bi-weekly cost for STD:

Annual Salary	Bi-Weekly Income	Bi-Weekly Cost for STD Buy-Up
$52,000.00	$2,000.00	$0.00
$55,000.00	$2,115.38	$2.52
$60,000.00	$2,307.69	$6.71
$65,000.00	$2,500.00	$10.90
$70,000.00	$2,692.31	$15.09
$75,000.00	$2,884.62	$19.28
$80,000.00	$3,076.92	$23.48
Annual Salary	**Bi-Weekly Income**	**Bi-Weekly Cost for STD Buy-Up**
$85,000.00	$3,269.23	$27.67
$90,000.00	$3,461.54	$31.86
$95,000.00	$3,653.85	$36.05
$100,000.00	$3,846.15	$40.25
$104,000.00	$4,000.00	$43.60

Contributions for your STD coverage are withheld on a pre-tax basis, and benefits payable are subject to normal income taxes. CIGNA does not withhold federal or state taxes from STD benefit payments. You may want to consult your tax advisor to determine how this will impact your tax filing. CIGNA will provide you with a W2 for any STD payments received during the year.

CIGNA Identity Theft Program

As an additional benefit included in the company-paid basic STD you also have a CIGNA Identity Theft Program. This program is designed to help you combat Identity Theft by providing a resolution services to help you work through critical identity theft issues you may encounter.

Valuable Help When You Need It
CIGNA Identity Theft Program Provides:
A review of credit information to determine if an identity theft has occurred
An identity theft resolution kit and an identity theft affidavit for credit bureaus and creditors
Help with reporting an identity theft to credit reporting agencies
Assistance with placing a fraud alert on credit reports, and cancellation and replacement of lost or stolen credit cards
Assistance with replacement of lost or stolen documents
Access to free credit reports
Education on how to identify and avoid identity theft
$1,000 cash advance to cover financial shortages if needed
Emergency message relay
Help with Emergency travel arrangements and translation services

Services for Every Situation
CIGNA Identity Theft services are available no matter where or when you come under the attack of identity theft:
CIGNA assists with credit card fraud, and financial or medical identity theft
CIGNA provides real-time, one-on-one assistance - 24 hours a day, 365 days a year - in every country of the world
Unlimited access to CIGNA personal case managers until your problem is resolved
CIGNA website offers helpful information to reduce your risk of identity theft before it happens

If you suspect you might be a victim of identity theft, call CIGNA at 1-888-226-4567. A CIGNA personal case manager is standing by to help you. When calling please indicate that you are a member of CIGNA Identity Theft Program and Group #57.

Long-Term Disability Insurance

The Benefits by Design long-term disability plan is insured by CIGNA.

Long-term disability (LTD) insurance provides you and your family with additional protection against loss of income when you cannot work for an extended period of time. The LTD plan is designed to coordinate with the insured STD plan to provide continuous wage reimbursement benefits if you continue to be disabled. Benefits under the STD Plan are available for a maximum period of 26 weeks (182 days) which fully covers the 180-day waiting period that must be satisfied before you are eligible to receive LTD benefits.

Subject to claim approval by CIGNA, participants in the LTD plan may receive benefits equal to 60% of their base pay. The maximum benefit you may receive under this program is $10,000 per month. LTD benefits are coordinated with other disability benefits you may receive, such as Social Security or Worker's Compensation, to provide a total wage reimbursement equal to 60% of your base salary.

Please review the Administrative Leave Policy found in the AMWTP Employee Handbook for details on employment while on approved LTD.

The bi-weekly cost for LTD is $0.587 per $100 of base bi-weekly income. Premiums for LTD insurance are withheld on an after-tax basis. The chart below illustrates bi-weekly cost for LTD:

Annual Salary	Bi-Weekly Income	Bi-Weekly Cost for LTD
$20,000.00	$769.23	$4.52
$25,000.00	$961.54	$5.64
$30,000.00	$1,153.85	$6.77
$35,000.00	$1,346.15	$7.90
$40,000.00	$1,538.46	$9.03
$45,000.00	$1,730.77	$10.16
$50,000.00	$1,923.08	$11.29
$55,000.00	$2,115.38	$12.42
$60,000.00	$2,307.69	$13.55
$65,000.00	$2,500.00	$14.68
$70,000.00	$2,692.31	$15.80
$75,000.00	$2,884.62	$16.93
$80,000.00	$3,076.92	$18.06
$85,000.00	$3,269.23	$19.19
$90,000.00	$3,461.54	$20.32
$95,000.00	$3,653.85	$21.45
$100,000.00	$3,846.15	$22.58

Flexible Spending Accounts

Flexible spending accounts enable you to pay for qualified health care and dependent day care expenses with before-tax dollars. The Benefits by Design flexible spending account (FSA) program is administered by Aetna.

Grace Period Reimbursement Period

The Flexible Spending Account leverages the IRS allowed grace period for reimbursable services to be received. This grace period is two and a half months after the close of the calendar year. For 2016, Flexible Spending Account election services must be received prior to March 15, 2017, in order to avoid the IRS use-it or lose-it rules which govern the plan.

Unclaimed 2015 Reimbursements

Eligible services and expenses received during the 2015 grace period (first two and a half months of 2016) and unsubmitted claims received during calendar year 2015 must be submitted to Aetna for processing after December 31, 2015. A blackout period may apply while reimbursement records are being transferred from United Healthcare to Aetna. All blackout periods will be communicated in advance via Project Notes and/or emails to affected participants.

Health Care Spending Account

Even if you elect the medical and dental plans with the highest levels of coverage, you will probably still have to pay some health care expenses out of your pocket. With a health care FSA, out-of-pocket costs such as co-pays and deductibles can be paid with pre-tax dollars subject to IRS FSA regulations.

The most you can contribute to a health care FSA for 2016 is $2,500 annually. Your FSA election cannot be changed during the year unless you experience a qualified status change. (Even then, the change must be consistent with the qualified status change you experience.) *Please be careful in setting your FSA contribution amount since by law you will forfeit any money that you don't spend by the end of the 2016 grace period.*

FSA Reimbursable Items

Health care reform legislation passed by Congress and signed by the president in March 2010 changed some of the rules for health care flexible spending accounts. Starting January 1, 2011, you can no longer use a health care FSA to pay or be reimbursed for many over-the-counter (OTC) drugs or medicines without a prescription.

Many OTC supplies such as bandages will still be eligible for FSA purchase or reimbursement without a prescription.

If you use OTC drugs or medicines recommended by your doctor to treat a medical condition, you may want to ask your doctor for a prescription. You will purchase these drugs or medicines by paying for them yourself, then you can submit a claim, a receipt and a copy of the prescription to Aetna reimbursed from your FSA.

Following are examples of OTC items that will *require a prescription* for FSA purchase or reimbursement:

Acid controller	Hemorrhoid treatment
Acne medicine	Laxatives or stool softeners
Aids for indigestion	Lice treatments
Allergy and sinus medicine	Motion sickness medicines
Anti-diarrheal medicine	Nasal sprays or drops
Baby rash ointment	Ointments for cuts, burns or rashes
Cold and flu medicine	Pain relievers, such as aspirin or ibuprofen
Eye drops	Sleep aids
Feminine anti-fugal or anti-itch products	Stomach remedies

Examples of OTC items that may continue to be purchased with or be reimbursed from an FSA *without a prescription*:

Bandages	Diagnostic test and monitors (i.e. blood glucose)
Birth control	Elastic bandages and wraps
Braces or supports	First-aid supplies
Catheters	Insulin
Contact lens solution and supplies	Ostomy products
Crutches	Reading glasses
Denture cleaners and adhesives	Walkers, wheelchairs, and canes

Auto Pay

If you enroll in a Health Care Flexible Spending Account, your account is set up with Auto Pay. This process automatically deducts your eligible health care expenses from your health care FSA after your insurance processes your medical claim. If you have direct deposit, Aetna will deposit the amount into your personal bank account. Otherwise, Aetna will mail a check to your home address.

- How does it work?
    1. Visit your health care provider.
    2. Your health care provider sends in the claim to Aetna.
    3. Aetna pays the amount that your insurance covers.
    4. Based on what insurance covers, Aetna will process the FSA claim. If you have direct deposit, Aetna deposits the FSA payment into your bank account. If not, Aetna will mail a check to your home address.

- You can enroll online for direct deposit. Log in to your PayFlex member website and click on the Financial Center tab. Click on Enroll in Direct Deposit. Follow the steps for direct deposit set up**.**

If you have expenses that do not go through insurance, and you have funds in your FSA, you can:

- Use the online tool, "Pay Them," to pay your provider directly from your FSA.
- Pay for eligible expense with cash, check, or personal credit card. Then submit a claim for reimbursement.
- Submit a claim online at PayFlexDirect.com. You can also use the PayFlex Mobile app or fax/mail your claim form directly to PayFlex

Opting Out of Auto Pay

Health Care FSA is automatically set up with Auto Pay. However, you have the option to opt-out of Auto Pay.

- Log in to PayFlexDirect.com and click on the Financial Center tab.
- From the drop down menu, select health Plan Activity.
- Click on Health Plan Activity Options on the left side.
- Review and update your current automatic reimbursement settings. Then click Save.

Dependent Day Care Spending Account

Many of you pay for dependent day care services on a regular basis while you work. By participating in a dependent day care FSA, you can pay for your dependents' qualified day care expenses with pre-tax dollars.

The most you can contribute to a dependent day care FSA for 2016 is $5,000 annually. Your FSA contribution election cannot be changed during the year unless you have a qualified status change. Even then, the change in your FSA contribution amount must be consistent with the qualified status change you experience.

Please be careful in making your election, since by law you will forfeit any money that you don't spend by the end of the calendar year. Also, be aware that if you are divorced, you must generally have physical custody of your dependent children to participate in this program. Please contact your tax advisor for additional information.

To be reimbursed from your spending account(s) for eligible health care and dependent day care expenses, you must provide either a receipt, written statement, or an explanation of benefits. The FSA claim form is available on the HR Benefits webpage.

Pre-Paid Legal Services

The Pre-Paid Legal Services program gives participants affordable access to over 6,000 of the highest rated attorneys nationwide. The plan emphasizes the importance of preventive legal care in keeping minor problems from becoming serious (or financially devastating), and offers participants assistance with many common legal needs. Pre-Paid Legal Services offers three different plan options.

1. **Standard Plan**
   - Preventive legal services, including legal document review and will preparation/maintenance, name change, adoption, and uncontested separation/divorce filing. Participants may access the program for the initial preparation of wills at no out-of-pocket cost.
   - Motor vehicle legal services, including moving violation representation, defense of criminal charges, and personal injury collection assistance.
   - Trial defense services, including defense of civil and job-related criminal actions, and pre-trial and trial assistance. Employees build up additional available hours for these needs each year they participate in the program.
   - IRS legal services, including representation for audit purposes.
   - Other legal services at a 25% discount from the Provider Attorney's standard or corporate hourly rate.

2. **Identity Theft Shield**
   - Credit Report evaluation, including up-to-date credit report through Experian at no added cost, a personal credit score calculated by an independent scoring service, and a detailed analysis of personal credit score.
   - Continuous credit monitoring, including prompt notification when new accounts have been opened in your name, derogatory notations have been added to your credit report, public records have been added to your report, inquiries have been made against your report, and a change of address has been requested.
   - Identity restoration includes a trained expert taking the steps to restore your name and credit for you. This expert will do the following:
     - Help correct identity theft issues you have with affected agencies and institutions, including: credit card companies, financial institutions, all three credit repositories, Federal Trade Commission, Social Security Administration, Department of Motor Vehicles, U.S. Postal Service, law enforcement personnel, and other organizations that may be affected.
     - Fraud alert notifications will be sent on your behalf to all three credit repositories, Social Security Administration, Federal Trade Commission, U.S. Postal Service, and affected credit card companies and financial institutions.
     - Proactive searches of applicable local and national databases will be made on your behalf to look for information you may not be aware of including criminal activity in your name in your county's records and certain federal watch lists, Department of Motor Vehicle records in your state, unknown addresses affiliated with your name, and banking activity in your name reported as fraudulent.

3. **Comprehensive**
    - Comprehensive coverage combines the plan features of the Standard Plan and Identity Theft Plan.

Employees enrolled in this plan have coverage in all 50 states and Canada, for themselves and their family members as follows:

- The employee's spouse.
- The employee's dependent children up to age 26 provided they live at home and have never married.
- The employee's dependent children up to age 26 provided they are attending college in the United States and have never married.

Policies will be offered on a family basis. Therefore, the premiums are the same if you are enrolling yourself or yourself and eligible dependents**.** Contributions for Pre-Paid Legal Services coverage are taken on an after-tax basis. Shown below are the 2016 bi-weekly contribution rates for the Pre-Paid Legal plans.

Bi-Weekly Employee Contributions	**Plan**
Standard Family	$7.36
Identity Theft Family	$7.36
Complete Coverage Family	$13.34

Coverage under the Pre-Paid Legal Services Plan is fully portable and can be continued automatically as a separate policy (with no increase in premium cost) if your employment with ITG terminates.

AMWTP Employee Investment Plan

Participation in the AMWTP Employee Investment Plan including changes in contributions and investment options may be changed at anytime. Even though you are not required to take any action on your Investment Plan during Annual Enrollment, many choose to update their personal contributions or investment goals for the upcoming calendar year.

The AMWTP Employee Investment Plan is administered by Vanguard. Log on to your account at www.vanguard.com for 24-hour access to information about your account, your plan's funds, and Vanguard's financial planning and advice services. Vanguard can also be reached by phone at 1-800-523-1188 Monday through Friday from 6:30 a.m. to 7:00 p.m. Mountain Time.

Purpose of the Plan

The AMWTP Employee Investment Plan is designed to help you reach your long-term financial goals, especially retirement. You contribute to the plan through automatic payroll deductions and you benefit from special tax advantages.

Eligibility and Enrollment

Participants in the Idaho National Laboratory (INL) Employee Retirement and INL Employee Investment Plan are not eligible to participate in the AMWTP Employee Investment Plan.

You are eligible to participate in the plan on the first day you are employed with the company. To enroll go to www.vanguard.com/enroll or call Vanguard at 1-800-523-1188. To enroll online, you will need your plan number 093968. You will be asked the percentage of your pay you want to contribute and how you want to invest among the fund choices available. Your enrollment will be completed as soon as administratively possible.

At the time of enrollment, unless you indicate otherwise, 100% of your contributions will be invested in a date-specific Vanguard Target Retirement Fund. You can change your investment elections after your account is established by visiting www.vangaurd.com or contacting Vanguard at 1-800-523-1188.

Beneficiaries

Be sure to name beneficiaries for your plan account. Properly designating beneficiaries ensures that, when you die, your hard-earned savings are distributed directly to your loved ones according to your wishes.

You can name your beneficiaries by following these simple steps:

1. Log on to www.vanguard.com
2. Select My Profile
3. Select Beneficiaries

Or call Vanguard Participant Services at 1-800-523-1188.

Employee Contributions

You can contribute from 1% to 50% of your salary on a pre-tax basis and/or ROTH basis. You can also contribute from 1% to 50% of your salary on an after-tax basis. Your combined pre-tax, ROTH, and after-tax contributions cannot exceed 50%. The IRS also limits plan contributions. For current IRS limits, visit www.vanguard.com.

If you contributed to a previous employer's plan this year, be aware that the annual IRS limit applies to the sum of your contributions to all employer plans for the current year. You should monitor your contributions to ensure that your total contributions for the current year do not exceed the annual IRS limit.

If you are age 50 or older, or will turn 50 by year's end, and you contribute the maximum allowed, you may make catch-up contributions. Catch-up contributions allow you to save above the normal IRS annual limit on a pre-tax basis.

Company Contributions

For every $1 you contribute (up to 5% of your pay), the company will contribute $1 to your account. Matching contributions will be applied to your pre-tax, ROTH, after-tax, and catch-up contributions.

In addition, you are immediately eligible to receive the company nonmatching contributions of 4% of your pay to your account each pay period whether you contribute to the plan or not.

Accessing Your Account

You can conduct the following account transactions anytime by logging on to www.vanguard.com or calling Vanguard at 1-800-523-1188:

- Join the plan
- Stop or change your payroll deductions
- Change how your contributions are invested
- Move money between funds
- Request withdrawals

IDAHO TREATMENT GROUP, LLC
Advanced Mixed Waste Treatment Project
-Important Notice-

Protected Health Information

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the AMWTP group health plan (the "Plan") or others in the administration of your claims and certain rights that you have. For a complete detailed description of all privacy practices, as well as your legal rights, please refer to the Plan's privacy policies.

AMWTP and the Plan are committed to protecting your personal health information. AMWTP and the Plan are required by law to (1) make sure that any medical information that identifies you is kept private; (2) provide you with certain rights with respect to your medical information; (3) give you a notice of AMWTP and the Plan's legal duties and privacy practices; and (4) follow all privacy practices and procedures currently in place.

The Plan may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment of any medical treatment and for any other Plan operation. The Plan will disclose your medical information to certain AMWTP employees for plan administration functions; but those employees may not share your information for employment-related purposes. The Plan also may use and disclose your personal health information without your permission, as allowed or required by law. Otherwise, the Plan must obtain your written authorization for any other use or disclosure of your medical information. AMWTP and the Plan cannot retaliate against you if you refuse to sign an authorization or revoke an authorization you had previously given.

You have the right to inspect and copy your medical information, to request correction of your medical information and to obtain an accounting of certain disclosure of your medical information. You also have the right to request additional restrictions or limitations be placed on the use or disclosure of your medical information or that communications about your medical information be made in different ways or at different locations.

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Office for Civil Rights. AMWTP and the Plan will not retaliate against you for making a complaint.

Important Notice from Idaho Treatment Group, LLC About Your Prescription Drug Coverage Under the AMWTP Employee Health Care Plan and Medicare

If you or your family members are not currently covered by Medicare and will not become covered by Medicare in the next 12 months, this notice does not apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the AMWTP Employee Health Care Plan and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans (also referred to as "Part D plans") provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ITG has determined that your prescription drug coverage for active employees offered under the AMWTP Employee Health Care Plan, on average for all plan participants, expects to pay out as much as the standard Medicare prescription drug coverage will pay. In other words, it is considered "Creditable Coverage" for the 2016 plan year.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher Medicare premium (penalty) if you later decide to enroll in Medicare prescription drug coverage.

When can you join a Medicare drug plan?

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare or each year from October 15 through December 7. However, if you lose your current Creditable Coverage through no fault of your own, you will also be eligible for a two-month "Special Enrollment Period" (or "SEP") to join a Medicare prescription drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are considering enrolling in a Medicare Drug Plan, you should compare your current coverage under the AMWTP Employee Health Care Plan, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to enroll in a Medicare prescription drug program you may also continue your employer coverage. In this case the employer plan primary and secondary coverage rules will apply. If you waive

or drop AMWTP Health Care Plan coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your AMWTP Health Care Plan coverage and do not enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later. If you go 63 continuous days or longer without Creditable Coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) for as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare prescription drug coverage.

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact Jennifer Robbins at 208-557-0930 for further information. NOTE: You will receive this notice annually and at other times in the future if prescription drug coverage for active employees under the AMWTP Health Care Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage
Read the "Medicare & You" handbook, which has detailed information about medicare plans that offer prescription drug coverage. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227).

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 1-800-772-1213.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show that you have maintained Creditable Coverage and therefore, are not required to pay a higher premium amount (penalty).

Date: September 30, 2015
Name of Entity/Sender: Idaho Treatment Group, LLC
Contact-Position/Office: Jennifer Robbins, 850 Energy Drive Suite, 100 Idaho Falls, ID 83401
208-557-0930

Contact Information

AMWTP 2016 PLAN	PROVIDER	PHONE / WEBSITE	ACCOUNT #
Aetna Navigator Link	Aetna	www.aetna.com	
Aetna Navigator Technical Support	Aetna	800-225-3375	
AD&D Insurance	Cigna	800-732-1603	OK-967174
Behavioral Health	Aetna	800-424-4660	847253
COBRA	PayFlex	888-678-7835	847254
Dental	Aetna	877-238-6200	847253
Disability, Short-Term/Long-Term	Cigna	800-362-4462	LK 8077
Employee Assistance Program (EAP 24/7)	Aetna	888-238-6232	847253
Flexible Spending Account (FSA)	PayFlex	877-392-3862	847254
Identity Theft	Cigna	888-226-4567	Group #57
Informed Health Line (24-Hour Nurse)	Aetna	800-556-1555	847253
Investment Plan - New (AMWTP)	Vanguard	800-523-1188	093968
Investment Plan - Old (INL)	Vanguard	800-523-1188	091194
Life Insurance GUL	Cigna	800-828-3485	02-M104940
Medical Member Services (24/7)	Aetna	877-204-9186	847253
Pharmacy Mail Order	Aetna	888-792-3862	847253
Pharmacy Retail	Aetna	800-238-6279	847253
Pre-Paid Legal	Legal Shield	800-654-7757	23766
Vision	Aetna	877-973-3238	847253
		PHONE NUMBER	**CELL NUMBER**
Human Resources		557-6700	
HR Manager	Shannon Bowman	557-6460	881-8411
HR Assistant	Michelle Crystal	557-6390	
Benefits Specialist	Jonna Nielsen	557-6400	970-0516
Compensation Specialist	Jennifer Robbins	557-0930	351-2737
Labor Relations	Brett Stacey	557-6327	351-6986
Site HR Generalist	John Morgan	557-0946	351-6672
Site HR Generalist	Becky Whitacre	557-6642	881-7171
		PHONE NUMBER	**CELL NUMBER**
Absence Reporting		557-6600	
Accountability (Site)		557-7301	
Contracts & Logistics Manager	Jim Simonds	557-0973	351-5427
Employee Concerns	Hotline	866-845-6490	
Medical Occupational Nurse	Tyson Bates	557-6587	351-0184
Medical (SOMD)	Dr. Paul Creighton	557-6335	680-8296
Finance & Accounting Manager	Jason Killpack	557-0941	360-3199
Payroll	Sarah Bodily	557-6483	
Payroll	Wendy Davis	557-0939	
Road Report (AMWTP)		680-4400	
Security Manager	Jamie Stuart	557-6546	680-0868